



## Rehab-External Admission Checklist for Referring Facility

|     | ITEMS NEEDED PRIOR TO CONSULT                                                                                                                                                           | Date complete | Initials |
|-----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|----------|
| 1.  | Facesheet with accurate patient name, DOB, Insurance information ( needed to verify benefits) & ICD-10 codes                                                                            |               |          |
| 2.  | H&P                                                                                                                                                                                     |               |          |
| 3.  | Last 3 days medical and therapy progress notes, including medical plan of care                                                                                                          |               |          |
| 4.  | Social Work notes, any infectious disease notes                                                                                                                                         |               |          |
| 5.  | Imaging Reports ( will need imaging CD if patient transfers)                                                                                                                            |               |          |
| 6.  | List of Consulting services                                                                                                                                                             |               |          |
| 7.  | Medication list                                                                                                                                                                         |               |          |
| 8.  | Procedure list                                                                                                                                                                          |               |          |
| 9.  | Tracheostomy yes or no ( <b>MUST HAVE FIRST TRACHEOSTOMY CHANGE PRIOR TO ANY TRANSFER per our system policy</b> )                                                                       |               |          |
| 10. | Gastrostomy? Yes or No                                                                                                                                                                  |               |          |
| 11. | Ongoing monitoring, i.e.: labs, scans?                                                                                                                                                  |               |          |
| 12. | MEDICAL point of contact for Nurse Practitioner to call for questions                                                                                                                   |               |          |
|     | <b>ITEMS NEEDED WITH TRANSFER</b>                                                                                                                                                       |               |          |
| 13. | Tracheostomy? <b>MUST HAVE FIRST TRACHEOSTOMY CHANGE PRIOR TO ANY TRANSFER per our system policy</b> )                                                                                  |               |          |
| 14. | Discharge Summary to be faxed ahead of transfer ( ideal ) or sent with chart on transfer; if unable to fax prior, please send last 3 days of progress notes and any new imaging reports |               |          |
| 15. | Imaging CD to accompany child (ideal to get scans before kid comes)                                                                                                                     |               |          |